AMENDED IN SENATE APRIL 5, 2011

SENATE BILL No. 51

Introduced by Senator Alquist

December 15, 2010

An act to add Sections 1367.001 and 1367.003 to the Health and Safety Code, and to add Sections 10112.1 and 10112.25 to the Insurance Code, relating to health care coverage.

LEGISLATIVE COUNSEL'S DIGEST

SB 51, as amended, Alquist. Health care coverage.

Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care and makes a willful violation of the act a crime. Existing law prohibits a health care service plan from expending for administrative costs, as defined, an excessive amount of the payments the plan receives for providing health care services to its subscribers and enrollees.

Existing law provides for the regulation of health insurers by the Department of Insurance. The Insurance Commissioner is required to withdraw approval of an individual or mass-marketed ~~policy of disability~~ *health* insurance *policy* if the commissioner finds that the benefits provided under the policy are unreasonable in relation to the premium charged, as specified.

The federal Patient Protection and Affordable Care Act prohibits a health insurance issuer issuing health insurance coverage from establishing lifetime limits or unreasonable annual limits on the dollar value of benefits for any participant or beneficiary, as specified. The act also requires a health insurance issuer issuing health insurance coverage to *comply with minimum medical loss ratios and to* provide

an annual rebate to each ~~enrollee~~ *insured* if the *medical loss* ratio of the amount of the revenue expended by the issuer on costs to the total amount of premium revenue is less than a certain percentage, as specified.

This bill would require health care service plans and health insurers to comply with the requirements imposed under those *federal* provisions ~~to the extent required under federal law~~*, as specified. The bill would authorize the Director of the Department of Managed Health Care and the Insurance Commissioner to issue guidance and promulgate regulations to implement requirements relating to medical loss ratios, as specified*.

Because a willful violation of those requirements with respect to health care service plans would be a crime, the bill would impose a state-mandated local program.

The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.

This bill would provide that no reimbursement is required by this act for a specified reason.

Vote: majority. Appropriation: no. Fiscal committee: yes. State-mandated local program: yes.

The people of the State of California do enact as follows:

SECTION 1. Section 1367.001 is added to the Health and Safety Code, to read:

1367.001. To the extent required by federal law, every health care service plan that issues, sells, renews, or offers contracts for health care coverage in this state shall comply with the requirements of Section 2711 of the federal Public Health Service Act (42 U.S.C. Sec. 300gg-11) and any rules or regulations issued under that section, in addition to any state laws or regulations that do not prevent the application of those requirements.

~~SEC. 2. Section 1367.003 is added to the Health and Safety Code, to read:~~

~~1367.003. To the extent required by federal law, every health care service plan that issues, sells, renews, or offers contracts for health care coverage in this state shall comply with the requirements of Section 2718 of the federal Public Health Service~~

~~Act (42 U.S.C. Sec. 300gg-18) and any rules or regulations issued under that section.~~

SEC. 2. Section 1367.003 is added to the Health and Safety Code, to read:

1367.003. (a) Every health care service plan that issues, sells, renews, or offers health care service plan contracts for health care coverage in this state, including a grandfathered health plan, shall provide an annual rebate to each enrollee under such coverage, on a pro rata basis, if the ratio of the amount of premium revenue expended by the health care service plan on the costs for reimbursement for clinical services provided to enrollees under such coverage and for activities that improve health care quality to the total amount of premium revenue, excluding federal and state taxes and licensing or regulatory fees and after accounting for payments or receipts for risk adjustment, risk corridors, and reinsurance, is less than the following:

(1) With respect to a health care service plan offering coverage in the large group market, 85 percent.

(2) With respect to a health care service plan offering coverage in the small group market or in the individual market, 80 percent.

(b) Every health care service plan that issues, sells, renews, or offers health care service plan contracts for health care coverage in this state, including a grandfathered health plan, shall comply with the following minimum medical loss ratios:

(1) With respect to a health care service plan offering coverage in the large group market, 85 percent.

(2) With respect to a health care service plan offering coverage in the small group market or in the individual market, 80 percent.

(c) Every health care service plan shall submit its rates to the director pursuant to the requirements imposed under Section 1385.03 or 1385.04. If the director notifies a health care service plan that a filed rate does not comply with the requirements of law, it shall be unlawful for the health care service plan to implement that rate.

(d) (1) The total amount of an annual rebate required under this section shall be calculated in an amount equal to the product of the following:

(A) The amount by which the percentage described in paragraph (1) or (2) of subdivision (a) exceeds the ratio described in paragraph (1) or (2) of subdivision (a).

(B) The total amount of premium revenue, excluding federal and state taxes and licensing or regulatory fees and after accounting for payments or receipts for risk adjustment, risk corridors, and reinsurance.

(2) A health care service plan shall provide any rebate owing to an enrollee no later than August 1 of the year following the year in which the rate was in effect.

(e) (1) On or before July 1, 2013, the director may issue guidance to health care service plans regarding compliance with this section. This guidance shall not be subject to the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code). The director may also promulgate regulations regarding compliance with this section.

(2) The department shall consult with the Department of Insurance in issuing guidance under paragraph (1), in adopting necessary regulations, and in taking any other action for the purpose of implementing this section.

SEC. 3. Section 10112.1 is added to the Insurance Code, to read:

10112.1. To the extent required by federal law, every health insurer that issues, sells, renews, or offers policies for health care coverage in this state shall comply with the requirements of Section 2711 of the federal Public Health Service Act (42 U.S.C. Sec. 300gg-11) and any rules or regulations issued under that section, in addition to any state laws or regulations that do not prevent the application of those requirements.

~~SEC. 4. Section 10112.25 is added to the Insurance Code, to read:~~

~~10112.25. To the extent required by federal law, every health insurer that issues, sells, renews, or offers policies for health care coverage in this state shall comply with the requirements of Section 2718 of the federal Public Health Service Act (42 U.S.C. Sec. 300gg-18) and any rules or regulations issued under that section.~~

SEC. 4. Section 10112.25 is added to the Insurance Code, to read:

10112.25. (a) Every health insurer that issues, sells, renews, or offers health insurance policies for health care coverage in this state, including a grandfathered health plan, shall provide an annual rebate to each insured under such coverage, on a pro rata

basis, if the ratio of the amount of premium revenue expended by the health insurer on the costs for reimbursement for clinical services provided to insureds under such coverage and for activities that improve health care quality to the total amount of premium revenue, excluding federal and state taxes and licensing or regulatory fees and after accounting for payments or receipts for risk adjustment, risk corridors, and reinsurance, is less than the following:

(1) With respect to a health insurer offering coverage in the large group market, 85 percent.

(2) With respect to a health insurer offering coverage in the small group market or in the individual market, 80 percent.

(b) Every health insurer that issues, sells, renews, or offers health insurance policies for health care coverage in this state, including a grandfathered health plan, shall comply with the following minimum medical loss ratios:

(1) With respect to a health insurer offering coverage in the large group market, 85 percent.

(2) With respect to a health insurer offering coverage in the small group market or in the individual market, 80 percent.

(c) Every health insurer shall submit its rates to the commissioner pursuant to the requirements imposed under Section 10181.3, 10181.4, or 10290. If the commissioner notifies a health insurer that a filed rate does not comply with the requirements of law, it shall be unlawful for the health insurer to implement that rate.

(d) (1) The total amount of an annual rebate required under this section shall be calculated in an amount equal to the product of the following:

(A) The amount by which the percentage described in paragraph (1) or (2) of subdivision (a) exceeds the ratio described in paragraph (1) or (2) of subdivision (a).

(B) The total amount of premium revenue, excluding federal and state taxes and licensing or regulatory fees and after accounting for payments or receipts for risk adjustment, risk corridors, and reinsurance.

(2) A health insurer shall provide any rebate owing to an insured no later than August 1 of the year following the year in which the rate was in effect.

(e) (1) On or before July 1, 2013, the commissioner may issue guidance to health insurers regarding compliance with this section. This guidance shall not be subject to the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code). The commissioner may also promulgate regulations regarding compliance with this section.

(2) The department shall consult with the Department of Managed Health Care in issuing guidance under paragraph (1), in adopting necessary regulations, and in taking any other action for the purpose of implementing this section.

SEC. 5. No reimbursement is required by this act pursuant to Section 6 of Article XIII B of the California Constitution because the only costs that may be incurred by a local agency or school district will be incurred because this act creates a new crime or infraction, eliminates a crime or infraction, or changes the penalty for a crime or infraction, within the meaning of Section 17556 of the Government Code, or changes the definition of a crime within the meaning of Section 6 of Article XIII B of the California Constitution.

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